Assessment of Antenatal care services in Ahore block of Jalore disctrict (Rajasthan)

By:
Harshul

Under the Guidance of
Col. Dr. Ashok Kaushik

MBA in Health & Hospital Management
2014-2016

IIHMR UNIVERSITY

2015

INSTITUTE OF HEALTH MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

CERTIFICATE

This is to certify that Harshul has completed the summer internship at UNICEF, Rajasthan from 1st April to 31st May 2015 and has conducted the following project under my personal guidance,

"Assessment of Antenatal Care Services in Ahore block of Jalore district (Rajasthan)."

All the data related to the study is the primary data collected by himself.

The approach to the project has been sincere, scientific and analytical. The work is partial fulfilment to the course requirements recommended for the Master of Business Administration in Hospital and Health Management, 19th Batch from Institute of Health Management and Research, Jaipur.

I wish him success in all his future endeavours.

Col. Dr .Ashok Kaushik
Dean (Academic & Students Affairs)
IIHMR University, Jaipur

Col. Dr. Ashok Kaushik
Dean (Academic & Student Affairs)
IIHMR University, Jaipur

1, Prabhu Dayal Marg, Near Sanganer Airport, Jaipur- 302029, Rajasthan, India.
Ph.: 0141- 3924700, 2791431- 32, Fax: 0141 3924738, E-mail: iihmr@iihmr.edu.in, Web.: www.iihmr.edu.in

United Nations Children's Fund
State Office for Rajasthan
B-9, Bhawani Singh Lane
Opp.Nehru Sahkar Bhawan
C-Scheme, Jaipur 302001

Telephone 91 141 4090500
91 141 2222694
91 141 2222636

Facsimile 91 141 2221510

www.unicef.org

Dated : 30 June 2015 :

To Whom so Ever It May Concern

This is to certify that Mr. Harshul S/O Mr. Gopal Natani, student of IIHMR, University, Jaipur, Rajasthan has successfully completed 2 Months (1 April – 31 March, 2015) summer training at UNICEF Rajasthan. During his summer training he has worked on Health situation of Jalore. **Titled "ASSESSMENT OF ANTENATAL CARE SERVICES IN AHORE BLOCK OF JALORE DISTRICT, RAJASTHAN".** He has successfully completed the project assigned to him during summer training and his contribution to the study has been sincere, scientific and analytical.

He was also engaged in Assisting Training of **E-jan Swasthaya** Program for ANMs.

I wish his success in all his future endeavours.

30/6/15

Dr Apurva Chaturvedi
Health Officer
UNICEF, Rajasthan

unite for children

unicef

TABLE OF CONTENTS

ACKNOWLEDGEMENT

The success of any task would be incomplete without the expression of gratitude to the people who made it possible. I express sincere gratitude towards everyone who helped directly or indirectly incompletion of my Summer Training from UNICEF Rajasthan.

At the onset of my report, I would like to acknowledge my sincere thanks to our University, Institute of Health Management and Research, Jaipur for providing us platform to gain enough knowledge and skills in different aspects of health management.

I express my gratitude and regards to my mentor Col. Dr. Ashok Kaushik for his able guidance and useful suggestions which helped me in completing the project work.

Special thanks to our project coordinator Dr. Anil Agrawal, Dr. ApurvaChaturvedi and Dr. KapilAggarwal for the faith shown upon me and guidance given without which the assignment would not have been possible.

I would like to thank Mr. InderpalArora (FDC-Jalore) and frontline health workers for their help at various stages of my project.

I would also like to thank my faculty members without whom this project would have been a distant reality. My seniors and colleagues also hold a special mention here for believing in me and supporting me throughout summer training.

Finally, and most importantly, I would like to thank God for allowing me to complete my project, my beloved parents for their blessings and my friends for their help and wishes for the successful completion of this training.

Harshul

IIHMR University, Jaipur

EXECUTIVE SUMMARY

Ante Natal Care (ANC) services are considered to be the key element in primary health care delivery system of a country, which aims for a healthy society. Over the past 60 years, the maternal health situation in the country has been staggering despite several changes in a rapidly evolving socioeconomic environment. The roles and responsibilities of primary care physicians and frontline health workers have also been revised continuously in this context. With Millennium Development Goal 5 – Improve maternal health, the need for improving the standard of maternal care is more than ever.

Keeping in view the gap between target and reality, National Rural Health Mission (NRHM), now a component of National Health Mission (NHM) was launched in April 2005 to improve the rural healthcare delivery system and health status of the people. Accredited Social Health Activists (ASHAs) were introduced at the village level for motivating the beneficiaries to utilize ante natal care services provided by government health facilities. Under supervision of Auxiliary Nurse Midwives (ANMs), ASHAs were planned to play a role for connecting a bridge between community and government health facilities. These health care providers, along with Anganwadi workers (AWW), build the base of rural health care services in the country. Under the mission they seek to provide universal access to equitable, affordable and quality maternal health care as well as to bring improvement in health status of pregnant women.

During summer training with UNICEF Rajasthan, got an opportunity to understand and assess the Ante Natal Care services being provided by frontline health workers in Ahore block of Jalore district of Rajasthan. The criteria for assessment were early registration of pregnancy, minimum of 3 ante natal check-ups, Tetanus toxoid vaccination, counselling on diet and rest, supplementation, birth preparedness etc.

About the Organisation

UNICEF (UNITED NATIONS CHILDREN'S FUND):

- **UNICEF has been working in India since 1949. The largest UN organization in the country,** UNICEF is fully committed to working with the Government of India to ensure that each child born in this vast and complex country gets the best start in life, thrives and develops to his or her full potential.

- The challenge is enormous but UNICEF is well placed to meet it. The organization uses quality research and data to understand issues, implements new and innovative interventions that address the situation of children, and works with partners to bring those innovations to fruition.

- UNICEF uses its community-level knowledge to develop innovative interventions to ensure that women and children are able to access basic services such as clean water, health visitors and educational facilities, and that these services are of high quality. At the same time, UNICEF reaches out directly to families to help them to understand what they must do to ensure their children thrive.

- UNICEF also wants them to feel a sense of ownership of these services. That same knowledge and interface with communities enables the organization to tackle issues that would otherwise be difficult to address: the complex factors that result in children working, or the growing threat that HIV/AIDS poses to children.

What makes UNICEF unique in India?

- It has network of 13 state offices. These enable the organization to focus attention on the poorest and most disadvantaged communities, alongside its work at the national level.

- UNICEF knows that key to addressing these challenges are its partnerships with sister UN agencies, voluntary organizations active at the community level, women's groups and donors.

- The organization also works with an array of celebrities, including members of the Indian cricket team and leading actors from the Indian film industry, as well as hundreds of thousands of unnamed volunteers who tirelessly give their time and influence to ensure that, together, they are able to help every child realize his or her full potential.

UNICEF In Rajasthan

As a partner of choice for the Government of Rajasthan, UNICEF is working on a set of models and pilot interventions, particularly in tribal areas in the districts of Udaipur, Dungarpur, Barmer and Baran. The intent is to ensure the survival, growth and development particularly of children belonging to marginalized communities.

Child Survival

- Setting up and scaling up Special Newborn Care Units, with a focus on real time monitoring and quality of services.
- Supporting improvements in the care of women and their babies during childbirth through increasing the quality of services.
- Health system strengthening through supportive supervision and capacity-building.
- Demonstrating a mechanism to improve the quality of services in the most deprived blocks to address the issue of inequity.
- Innovations for real-time monitoring of survival and development outcomes.

Nutrition

- Offering a facility and community-based support and tracking mechanism to improve breastfeeding and complementary feeding. The special HajuSuru (healthy well-nourished child) strategy in the tribal districts of Banswada and Dungarpur promotes family empowerment in feeding through community monitoring and tracking.
- Supporting a high rate of dose for vitamin A supplementation, with two doses every six months.
- Working with the government towards universal salt idolization and tracking access and use of iodized salt at the family level.
- Improving care and treatment for children with severe acute malnutrition (SAM) and providing facility and community-based strategies to help support children with SAM.

Education

- Enhancing learning outcomes of children through transforming the teaching learning process, making it more student-centric, activity-based, learning-focused and equity-oriented.
- Introducing a continuous comprehensive assessment as part of the pedagogy in all schools by 2018. In 2014, 22,000 schools will implement Continuous and Comprehensive Evaluation (CCE) as their assessment system.
- Providing technical support to monitor learning outcomes in real time.
- Offering a school leadership programme to complementthe quality improvement initiative in schools.

- Lending technical support to create an enabling environment for early childhood education (ECE); putting in place a curriculum, syllabus and a state policy for ECE and facilitating coordination with the state Education Department for capacity development of Anganwadi workers and their continuous support on ECE.
- Supporting capacity enhancement of School Management Committees.
- Supporting capacity-enhancement of academic institutes, the State Institute for Education, Research and Training (SIERT) and District Institute for Education Training (DIET), to ensure all interventions to improve education standards can be realized.

Child Protection

- UNICEF in Rajasthan is working to strengthen systems for Child Protection by ensuring quality education to all children with a special focus on out-of-school, never-enrolled and drop-out children.
- It is building the capacities of and mobilizing families and the community to take collective action to protect their children and help them develop.
- To increase families' adult incomes and prevent child labour, UNICEF is enhancing access to service providers and social protection schemes for vulnerable families and children such as the widow pension, old age pension, AapkiBetiYojana, Palanhar and MukhyaMantriHunarVikashYojana.
- UNICEF is also helping to improve the state policy framework and delivery systems related to Child Protection; improve access to and the quality of social protection schemes and the Integrated Child Protection Scheme (ICPS); and assessing various Acts, policies and programs related to Child Protection.
- It is strengthening and supporting the capacity of the ICPS to promote and deliver the best services to the most vulnerable children in the state.
- Designing interventions to reduce child marriage, child labour, out-of-school children and corporal punishment in schools.

Water, Sanitation and Hygiene

- UNICEF is building the capacity for the government and communities to eliminate open defecation by supporting the development and implementation of effective behavior change strategies at the state level.
- Supporting the state to improve the quality of health care in health institutions by improving Water, Sanitation and Hygiene (WASH) facilities and practices through capacity-building of National Rural Health Mission (NRHM) stakeholders.
- Developing monitoring systems and providing access to evidence-based tools and guidelines and promoting key hygiene practices in schools through sustainable, simple and scalable models of WASH.

- Sharing scalable WASH approaches that address priority gaps and bottlenecks in delivering and promoting sanitation facilities and hygiene promotion.
- Supporting rural WASH sector development through improved management information systems (MIS) for WASH access and use, including identification and corrective action for the state's most marginalized areas.
- Creating an enabling environment for improved WASH facilities and practices in health centers through a convergence of Health and WASH programs in 100 centers in four priority districts.
- Creating an enabling environment to adopt key WASH practices in schools, through innovative technologies and child-centered approaches in the tribal districts of Udaipur and Durgapur.
- Supporting the state's institutionalization of the WASH validation system to monitor WASH outcomes on a regular basis.

Disaster Risk Reduction

Working with the State Disaster Management Authority to pilot risk-informed planning systems to improve disaster preparedness and response.

Communication for Development

- Developing strategic approaches to communication through the development of evidence–based and theory-driven communication strategies in the areas of the WASH (SHACS strategy), Health (RMNCH+A and RI), Child Protection (addressing social norms on the Prevention of Child Marriage and Child Labour), Education (community mobilization for the promotion of girls' education). These have been developed with the state government and UNICEF frameworks adopted by national flagships and have been customized for rollout across state.
- Building the capacities of frontline service-providers from government flagship programs so they can effectively engage with families and communities to promote social and behavior change in relation to key child survival and development issues.
- Using new technologies for Communication for Development (C4D): The potential of technologies such as the internet, digital tools, mobile phones and the like will be harnessed to communicate with families and frontline functionaries in a changing social and cultural context.

Assessment of Ante Natal Care services in Ahore block of Jalore district (Rajasthan)

Introduction:

According to MMR Bulletin 2011-13, Maternal Mortality Ratio (MMR) of India is 167 whereas for Rajasthan it is 244 maternal deaths for 100,000 live births. Similarly Maternal Mortality Rate of India is 11.7 but for Rajasthan it stands out to be 23.9 suggesting a lot of work needs to be done for improving the status of maternal health as far as Rajasthan is concerned.

To improve the health status of pregnant women and to prevent maternal deaths, ante natal care is one of the important pillars to achieve universal access to equitable, affordable and quality maternal health care as well as to bring improvement in health status of pregnant women.

Ante Natal Care is the systematic supervision of women during pregnancy to monitor the progress of foetal growth and to ascertain the wellbeing of mother and the foetus. A proper Antenatal check-up provides necessary care to the mother and helps identify any complications of pregnancy such as anaemia, pre-eclampsia, hypertension etc. in the mother and slow/inadequate growth of the foetus. Antenatal care allows for the timely management of complications through referral to an appropriate facility for further treatment. It also provides opportunity to prepare birth plan and identify the facility for delivery and referral in case of complications.

Suggested schedule for ANC check-ups:

- First check-up – Within 12 weeks, preferably as soon as pregnancy is detected.
- Second check-up – Between fourth and sixth month of pregnancy.
- Third check-up – Between seventh and eighth month of pregnancy.
- Fourth check-up – During ninth month of pregnancy.

Components of ANC:

- History taking – During the first visit, a detailed history of women needs to be taken to confirm the pregnancy and to identify whether there were complications during any previous pregnancy. While taking history, it is important to record the date of Last Menstrual Period (LMP) as this helps to calculate Expected Date of Delivery (EDD) and prepare a birth plan.

- Physical Examination – It includes measurement of Blood pressure, weight, height, presence of oedema, abdominal examination to measure fundal height, determination of foetal lie, auscultation of FHS.
  Measuring blood pressure at every visit is necessary to rule out hypertensive disorders of pregnancy. The weight taken at first visit should be treated as baseline weight and ideally women should gain 9-11 kg during her pregnancy. Measurement of height becomes necessary to know if women could have any complications during delivery. Any oedema of face, hands, abdominal wall is abnormal and should be referred immediately for further investigations.

- Investigations – It includes Haemoglobin estimation, testing the urine for presence of protein and sugar. Haemoglobin estimation helps in identifying whether the women is anaemic and needs iron supplementation. Detection of pre-eclampsia is

done through testing urine for the presence of protein (albumin). Presence of sugar in urine helps in diagnosing gestational diabetes.

- Interventions – It includes IFA supplementation, administration of TT injection, Micro-birth planning. During pregnancy there is need for increased intake of iron and folic acid due to which it becomes necessary to provide IFA supplementation. Counselling should also be given on side effects of IFA supplementation and methods to overcome them. The administration of TT injection is an important step in the prevention of maternal and neonatal tetanus.

- Counselling – Counselling should be given on various issues involving diet and rest to be taken, Birth spacing and contraceptive methods, various government schemes that promote institutional deliveries. Special emphasis should be given to dieat and supplementation to be followed during pregnancy. As there is high need to intake iron during pregnancy women should be counselled on eating iron rich foods like green leafy vegetables, whole pulses, jiggery, meat, poultry and fish.

OBJECTIVE:

- To assess the Antenatal Care services being provided in Ahore block of Jalore district of Rajasthan.

RESEARCH METHODOLOGY:

- STUDY DESIGN:

  A Cross-sectional study was conducted.

- STUDY AREA:

  The study area was Ahore block of Jalore district.

  Jalore as study area was specifically chosen because according to AHS 2012-2013, Jalore is at third last position in Rajasthan in terms of mother who received any antenatal check-up and in terms of mothers who had antenatal check-up in their first trimester it stands in second last position in Rajasthan.

- STUDY POPULATION:

  50 women who are either pregnant and should have received at least 2 ANC check-up or women who have delivered and their baby is one month old.

- STUDY PERIOD:

  The study was carried out for 2 months from 1st April 2015 to 31st May 2015.

- SAMPLING DESIGN:

  Non-probability sampling method was applied.

- DATA COLLECTION:

  Primary data was collected through face to face interviews with the beneficiaries with the help of semi structured questionnaire.

- DATA ANALYSIS:

  Frequencies and percentages of different parameters of ANC services were found using SPSS software.

RESULTS:

Variable	Frequency	Percent(%)
Age		
19-24	23	46
25-30	23	46
30+	4	8
Mean 25.8 Minimum 19 Maximum 42		
Educational Qualification		
No schooling	34	68
Primary	10	20
Secondary	5	10
Senior secondary	1	2
Economic status		
Above poverty line	34	68
Below poverty line	16	32
Pregnancy		
First	9	18
Second	13	26
Third	13	26
Fourth	10	20
Fifth	3	6
Sixth	2	4
JSY Registered		
Yes	13	26
No	37	74
Antenatal check-ups		
1	6	12
2	20	40
3	24	48
4	0	0

Table 1: Socio-demographic and pregnancy related characteristics.

Early registration of pregnancy:

Value	Frequency	Percent(%)
Yes	15	30
No	35	70

Table 2

Figure 1*

Figure 2*

Figure 3*

*Note: The four tests which are included in the figures are estimation of haemoglobin, measurement of blood pressure, weight and urine test.

TT Vaccine administered:

Value	Frequency	Percent(%)
Yes	50	100
No	0	0

Table 3

IFA tablets received:

Value	Frequency	Percent(%)
Yes	49	98
No	1	2

Table 4

Place of receiving tablets:

Value	Frequency	Percent(%)
CHC	18	36
SC	22	44
AWC	1	2
Private	8	16
Not received	1	2

Table 5

Quantity of IFA tablets received:

Value	Frequency	Percent(%)
0	1	2
<60	15	30
60-90	29	58
100 or more	5	10

Table 6

Figure 4

Height measured:

Value	Frequency	Percent(%)
Yes	5	10
No	45	90

Table 8

Abdominal check-up conducted:

Value	Frequency	Percent(%)
Yes	22	44
No	28	56

Table 9

Way of conducting abdominal check-up:

Value	Frequency	Percent(%)
Lied down on bed	22	44
Lied down on floor	0	0
No check-up	28	56

Table 10

Foetal heart rate measured:

Value	Frequency	Percent(%)
Yes	22	44
No	28	56

Table 11

Presence of oedema and fever during pregnancy:

Value	Frequency	Percent(%)
Oedema		
Yes	13	26
No	37	74
Fever		
Yes	5	10
No	45	90

Table 12

Figure 5

Figure 6

Figure 7

Transport for visiting ANC clinic:

Value	Frequency	Percent (%)
Public transport	9	18
Personal vehicle	7	14
Walking	34	68

Table 13

Figure 8

Place of delivery decided:

Value	Frequency	Percent (%)
Yes	41	82
No	9	18

Table 14

DISCUSSION:

In this study no women received 4 antenatal check-ups whereas only 48% of women received 3 antenatal check-ups, 40% of women received 2 check-ups and 12% of women could manage only 1 ANC check-up. Early registration of pregnancy which is very necessary to provide care and manage any complication was found to lacking as 70% of women were not registered in first 12 weeks of pregnancy.

Figure 1, 2 and 3 shows no. of tests conducted under first three ANC check-ups, interestingly percentage of women who got 4 tests (blood pressure, haemoglobin, urine, weight) done were reducing with the proceeding check-ups i.e. 88% in first check-up, 72% in second and 38% in third check-up. Half of the respondents didn't got their third check-up done. There could several reasons for not getting their complete check-ups but one of the prominent reasons were told by ANMs that many women in their last trimester go to their maternal house and come back after delivery due to which they are not able to conduct all the check-ups.

One of the positives from this study was that all the respondents got the TT vaccine administered and nearly all (98%) women got the IFA supplementation. But when Quantity of IFA received is analysed it is found that merely 10% of women got 100 IFA tablets and 58% women got 60 to 90 tablets and 30% got less than 60 tablets. Way of taking tablets wasn't very satisfying as 54% women were taking it any time during the day irrespective of water, milk or tea and 20% women were not taking tablets because of its side effects and only one-fourth of the respondents said they take it in night with water.

Physical examination was poor as 90% of women never got their height measured and 44% women said that their abdominal check-up and foetal heart rate was measured. More than one fourth(26%) of the women agreed to the presence of oedema during pregnancy whereas 10% of respondents talked about fever during pregnancy.

When analysed knowledge level of respondents regarding diet and rest comprising of 2 hours of additional sleep, intake of 1.25 times of regular diet and intake of green leafy vegetables it was found that 74% of women knew about rest whereas 70% knew about diet to be followed during pregnancy. These figures are similar to whether women received counselling on diet and rest as 70% agreed to that they were counselled on this issue. Counselling on other matter like contraception and government policies to promote institutional deliveries were fairly less as 58% agreed to counselled on contraception and 34% on government policies.

It was surprising to see who accompanied them to ANC clinic as data suggests that 60% go for their check-ups alone whereas 16% and 24% were accompanied by their husband and mother in-law respectively. When asked about transport used by them to go to ANC clinic it was found that 68% women walk and reach their clinic whereas 18% used public transport and remaining 14% went by personal vehicles. It was important to know whether these women were satisfied with the services they get it was found that 82% were satisfied with the

care of doctors and nurses and 82% were satisfied with the services they get. Deciding the place for delivery is very necessary and it was found that 18% were not sure about it and remaining 82% said they have/had decided place for delivery before time.

LIMITATIONS:

Conversing in local language was an issue specially while interacting with villagers and generally pregnant women choose to go to their maternal house in their third trimester and return after delivering the baby so achieving the target sample took some time.

KEY FINDINGS/OBSERVATIONS:

- While interacting with the local community specially villagers I came to know about a custom wherein women are not supposed to sit on chair while there is a male member present in the house. Even the pregnant women refused to sit while I took interview of her for my project.
- During these two months I got opportunity to visit various health facilities specially sub centres. Out of many sub centres I visited I found sub centre of Sanwada hardest to reach as there was lack of public transport due to non-availability of proper road. This could be a problem for people living there to access healthcare due to lack of transport.

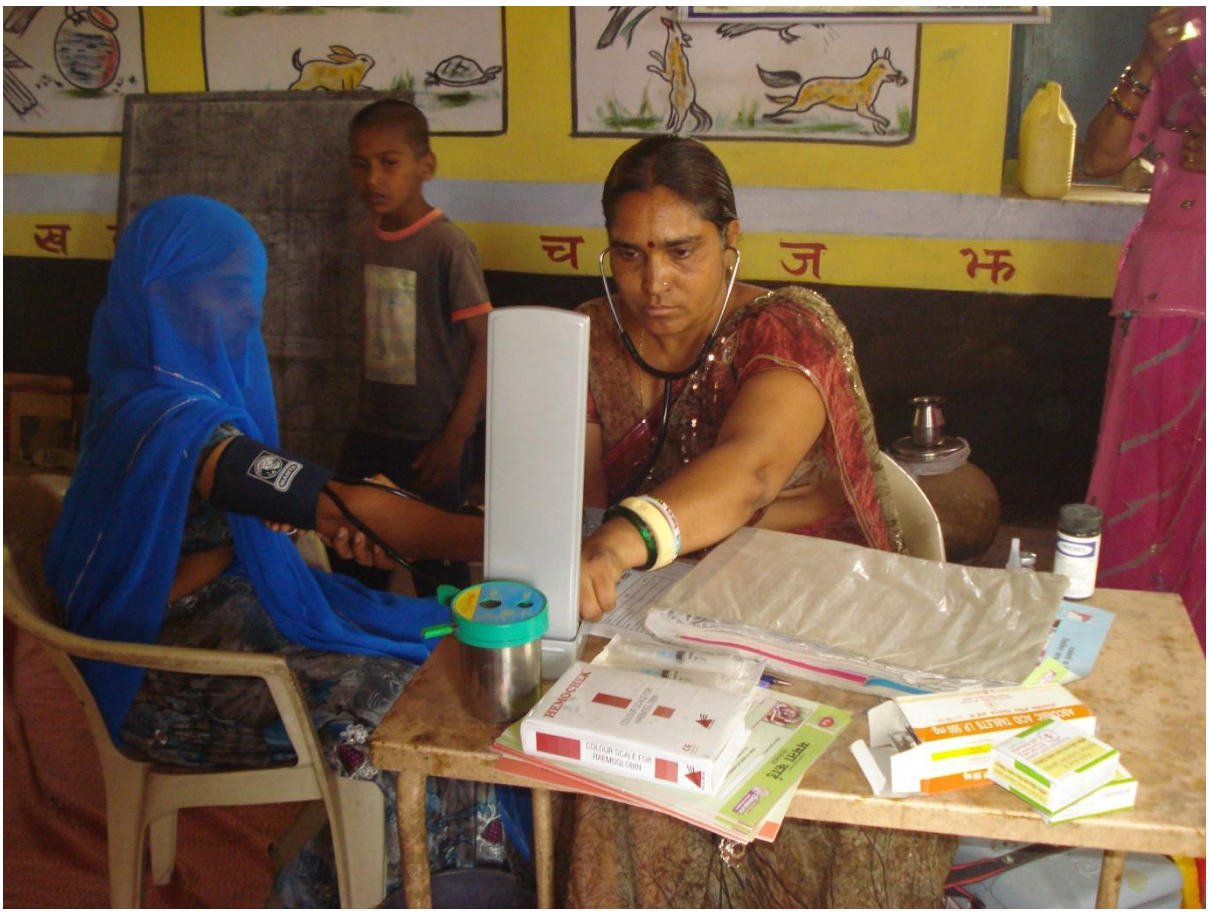

Figure 9: ANM conducting blood pressure measurement.

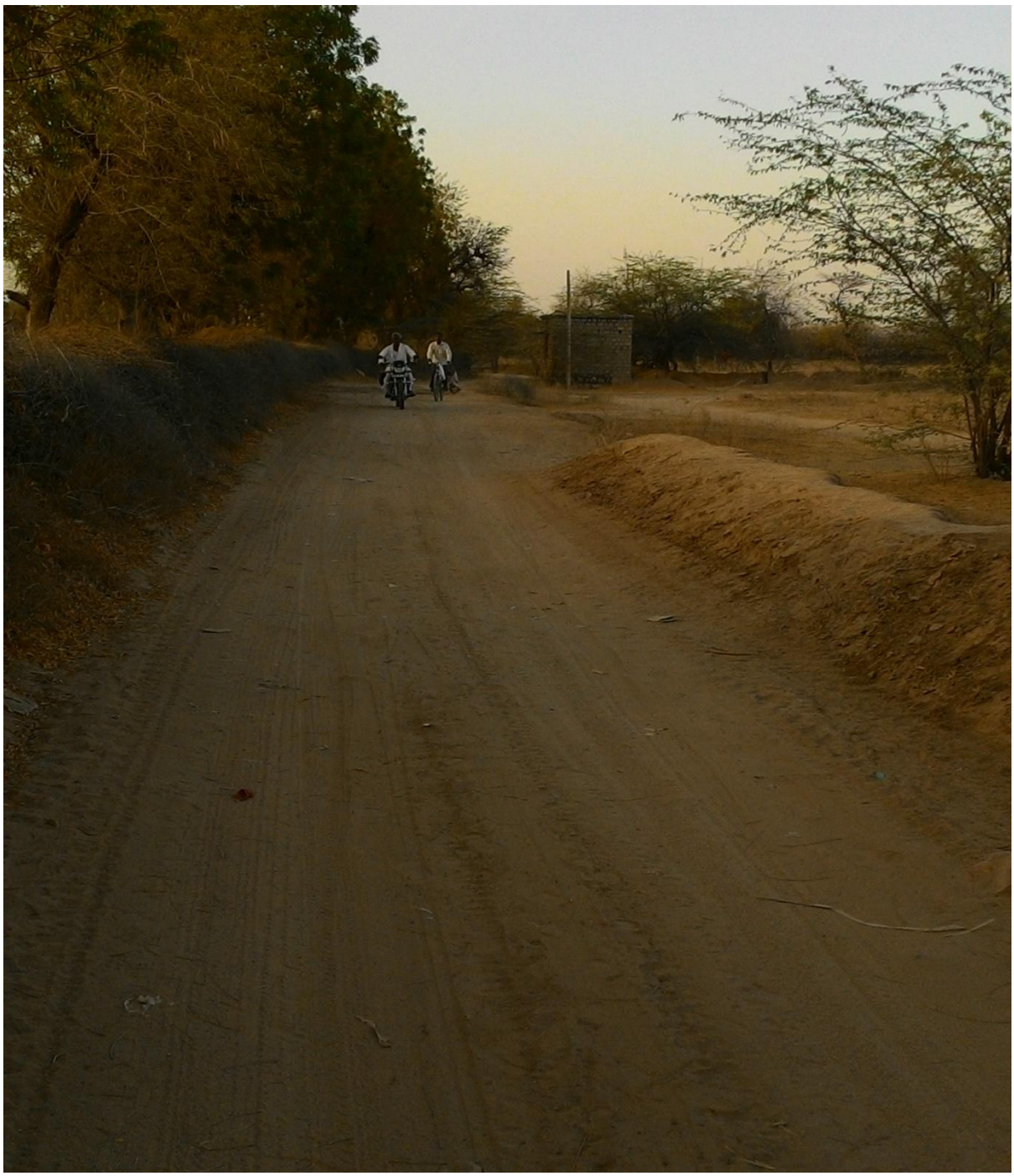

Figure 10: Way to Sanwada sub centre depicting lack of proper roads.

REFERENCE:

1) MMR Bulletin, 2011-2013.
2) AHS 2010-2011.
3) Guidelines for Antenatal care and skilled attendance at birth by ANMs/LHVs/SNs, NRHM.
4) AHS Factsheet Rajasthan 2012-2013.
5) District Factsheet: Maternal and child health indicator(2013-2014 & 2014-2015), NRHM Rajasthan.
6) Quality assessment of the practise of focused antenatal care (FANC) in rural and urbanprimary health centres in Ekiti state. Ikeoluwapo O. Ajayi, Damilola C. Osakinle, Eunice O. Osakinle, Open Journal of Obstetrics and Gynaecology, 2013(3), 319-326.